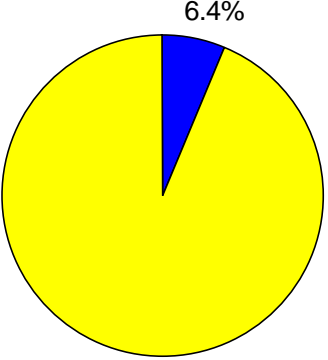


Fairfax-Falls Church Community Services Board

106-03-Mental Health Emergency and Crisis Services

| Fund/Agency: 106 | Fairfax-Falls Church Community Services Board | |
|---|---|--|
| Personnel Services | \$5,450,041 | <p style="text-align: center;">CAPS Percentage of Agency Total</p>  <p style="text-align: center;">6.4%</p> <p style="text-align: center;">93.6%</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> ■ Mental Health Emergency and Crisis Services ■ All Other Agency CAPS </div> |
| Operating Expenses | \$1,396,807 | |
| Recovered Costs | \$0 | |
| Capital Equipment | \$0 | |
| | | |
| Total CAPS Cost: | \$6,846,848 | |
| | | |
| Federal Revenue | \$0 | |
| State Revenue | \$3,125,040 | |
| User Fee Revenue | \$366,196 | |
| Other Revenue | \$161,355 | |
| | | |
| Total Revenue: | \$3,652,591 | |
| | | |
| Net CAPS Cost: | \$3,194,257 | |
| | | |
| Positions/SYE involved in the delivery of this CAPS | 73/72 | |

► CAPS Summary

Mental Health Emergency and Crisis Services - The priority treatment population for Mental Health Emergency and Crisis Services are adults, adolescents, and children who are actively suicidal, acutely homicidal due to mental illness, or so mentally ill and unable to care for themselves that their lives are in imminent jeopardy. Prompt and expert intervention can literally be a matter of life and death. The mission and focus of Emergency and Crisis Services is to "save lives, stabilize the crisis, and connect patients with outpatient care once it is safe to do so."

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Depending upon a patient's needs and willingness to accept treatment, services may be delivered in a walk-in psychiatric emergency room at three locations, in the field through the Mobile Crisis Unit, in a Crisis Care therapeutic residential facility or Women's Crisis Shelter, or through psychiatric hospitalization - either voluntary or involuntary. Services provided include: risk assessment; crisis intervention and crisis stabilization; psychiatric evaluation; emergency medications dispensed or prescribed; admission to a Crisis Care residential facility, Women's Crisis Shelter or a detoxification center; and psychiatric hospitalization - both voluntary and involuntary. In addition to walk-in services, inpatient services, and crisis residential services, Emergency and Crisis Services also fields rapid response teams with specialized training in hostage or barricade situations, mass casualty or disaster situations, and to acutely traumatized public safety personnel. The Division is also responsible for staffing every commitment hearing held in the County with psychologists who act as "Independent Evaluators" for the Court.

The psychiatrists, clinical psychologists, and clinical social workers who work in Emergency and Crisis Services are seasoned, senior clinicians with specialized clinical training and skills. However, they also must be thoroughly grounded in the mobilization of community resources. It is impossible to successfully treat depression or lower the risk of suicide when the patient has no food or a place to stay. So, Mental Health and Crisis Services accepts referrals from and makes referrals to a variety of other agencies and programs, including:

- Department of Family Services (food stamps, emergency shelter)
- Health Department (to treat general medical conditions)
- Fairfax County Public Schools (FCPS)
- Child and Adult Protective Services
- Virginia Employment Commission
- Department of Housing
- Police Departments
- Fire and Rescue Services

Mental Health Emergency and Crisis Services operate under the auspices of multiple sections of Virginia Code. Community Service Boards in Virginia are mandated to provide 24 hours a day, 365 days a year comprehensive psychiatric emergency services under the Code of Virginia, as amended. Virginia Code also mandates sole CSB responsibility for evaluation of patients for involuntary hospitalization in the Commonwealth and authorizes Emergency and Crisis Services' clinicians to recommend and facilitate involuntary hospitalizations. It also mandates that all clinicians who initiate involuntary hospitalization be certified, after having successfully completed a joint State and local specialized training program. The Critical Incident Stress Management/Disaster Response Team is part of the Fairfax County Disaster Operations Plan that is mandated under the Code of Virginia and the Code of Fairfax County.

Emergency Services - CSB provides 24 hours a day, comprehensive walk-in psychiatric emergency services to persons critically at risk. Patients may come in by themselves, be accompanied by a friend or relative, be referred by various County or private agencies, or be brought in by the police - voluntarily or involuntarily. In addition to crisis intervention and crisis stabilization, "walk-in" services include: hospital pre-admission screenings; pre-detention evaluations; psychiatric hospitalizations; evaluations for, and admissions to, the Crisis Care Program or the Fairfax County Detoxification Center; psychiatric evaluations to rule out medical etiologies of psychological symptoms; medication evaluations, prescriptions, or dispensation of medications; and consultation and assistance to Police, Fire and Rescue, Magistrates, Adult and Juvenile Detention Centers, schools, hospitals (Fairfax, Mt. Vernon, Fair Oaks, Reston, and Dominion), Department of Family Services (Child Protective Services and Adult Protective

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Services) and other human services agencies, and families of patients. This program also serves as the off-hour emergency service for Mental Retardation Services and Alcohol and Drug Services, the Northern Virginia Regional Deaf Services Program, and Crisis Link (formerly Northern Virginia Hotline).

Mobile Crisis Services

- The Mobile Crisis Unit (MCU) is a rapid response team that provides expert community crisis intervention and resolutions in high-risk cases of individuals who are dangerous to themselves or to others, or who are unable to care for themselves because of mental illness and who are unwilling or unable to seek help. The MCU accepts referrals and requests from Police, Courts, Fire and Rescue, families, community members, Child Protective Services, Adult Protective Services, and other County and community organizations and agencies. The MCU prioritizes its cases by level of risk, with the highest risk cases at any given moment responded to first. Examples of the kinds of patients seen by the MCU in the community include those with psychotic disorders, people who are suicidal or homicidal, people with mania or depression, people who are dually diagnosed (both seriously mentally ill and substance dependent or abusing), etc. Services provided include: crisis intervention; hospital pre-admission screenings; pre-detention evaluations; evaluations for and admissions to the Crisis Care Program and Fairfax County Detoxification Center; back-up clinical services to the Adult Detention Center and Juvenile Detention Center, and on-scene consultation to Police and Fire and Rescue. In multi-agency cases, one of the MCU's objectives is to free others (such as police officers or paramedics) from a scene so that they may respond to other, non-psychiatric emergencies.
- The **Hostage/Barricade Team** is a rapid response team that is on-call 24 hours a day, seven days a week, along with police SWAT and police negotiators. On scene, the Team develops a psychological profile of the hostage-taker, gathers critical clinical information, monitors negotiations and recommends negotiating strategies and tactics, acts as a resource to the SWAT commander on decisions that a situation is no longer negotiable and tactical assault is warranted, facilitates involuntary psychiatric hospitalization when needed, treats released hostages, works with families of victims, recommends crowd control strategies when needed, and works with families of hostage taker/barricader – especially if incident ends in his or her death. The Team also provides regular clinical training for police members of the team, participates in training “first responder” police officers which includes “full-dress” training simulations.
- The **Critical Incident Stress Management (CISM)/Disaster Response Team** is a rapid response team that is on-call 24 hours a day, seven days a week to assist police officers, fire fighters, paramedics, and any other County employees who have been exposed to a psychologically traumatic event (line of duty deaths, death of a child, mass or multiple casualty events, workplace violence, or the traumatic death of a co-worker). The Team is able to provide various types of expert crisis intervention ranging from on-scene work for long duration public safety events (such as the Oklahoma City tragedy) to brief defusings immediately after an event, to full scale formal Critical Incident Stress Debriefings. Examples of CISM services include working with Fairfax County public safety personnel after the Oklahoma City disaster, the embassy bombing in Nairobi, and earthquakes in Armenia, the Philippines, Turkey and elsewhere. Examples of more local clinical services include debriefings after a fatal elevator accident, after an employee suicide, after a violent death in a County park, etc. In addition to the kinds of clinical services just described, the Disaster Response Team is also able to work on-scene with victims, survivors, and families in disaster situations such as plane crashes, weather emergencies, or other mass casualty incidents, and to provide emergency psychological services at emergency evacuation shelters set up by the American Red Cross and the Department of Family Services.

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- The **Civil Commitment Program** provides independent evaluators to the General District Court prior to and at every psychiatric commitment hearing conducted in Fairfax County, as required by the Code of Virginia. Independent Evaluators are licensed clinical psychologists or psychiatrists. After a psychiatric temporary detention, but before the commitment hearing (which occurs two days later), they are required to conduct a clinical evaluation of the detainee independent of the evaluation done by the clinicians who initiated the Temporary Detention Order. They must determine if: (i) the patient is an imminent danger to self or others; or (ii) is so seriously mentally ill as to be substantially unable to care for self; and (iii) that there is no less restrictive alternative to commitment in a psychiatric hospital. The Independent Evaluator provides a clinical report to the Special Justice who conducts the commitment hearing, as well as expert testimony during the hearing itself. The Independent Evaluator is a code-specified gatekeeper; if the Independent Evaluator testifies that there is no further risk of imminent dangerousness, the patient is released and no commitment hearing may be held.
- The **Entry and Referral Program** is the primary point of contact for new requests for services. Entry and Referral assesses a caller's mental health needs, conducts a risk assessment and assesses the need for emergency intervention, and, if needed, makes the necessary referral. Following the assessment, Entry and Referral schedules the initial face-to-face evaluation and/or makes referrals to other appropriate community resources or private providers.
- The **Crisis Care Program** was developed specifically to provide a community-based alternative to psychiatric hospitalization. This intensive, short-term residential treatment program provides psychiatric crisis stabilization services to adults with severe and persistent mental illness (including those with substance dependence) who are experiencing acute psychiatric crises. Services include: comprehensive risk assessment; crisis intervention and crisis stabilization; individual, group, and family therapy; psychiatric evaluation; medication evaluations and medication management; substance abuse counseling; psychosocial education and assistance with skills of daily living; and short-term case management.
- The **Women's Crisis Shelter** is a 17-bed crisis residential program for women and children who are fleeing imminent physical domestic abuse and is part of the State-certified County Domestic Abuse Program. Specialized services offered include: crisis intervention; individual and group counseling; children's counseling; assistance with court and in obtaining legal services; assistance in obtaining employment, housing, health care, and meeting other needs; and community education to other professionals. Interpreter services and culturally sensitive counseling and materials are available for language minority clients. In FY 2002, the program will be adding 12 beds.
- **Inpatient** - The CSB purchases access to three acute care psychiatric beds from the Inova Mt. Vernon Hospital for medically indigent residents of Fairfax County and the Cities of Fairfax and Falls Church. As a part of the contract, the CSB deploys a full-time clinician who is a member of the inpatient unit treatment team and provides discharge planning and case management services for all CSB clients admitted to the hospital.

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Quality Assurance and Staff Development

For information on CSB's comprehensive Quality Improvement (QI) Plan, Risk Management Plan, and CSB-wide training and staff development initiatives, please refer to the Overview section.

Specific to this CAPS, additional quality improvement activities include:

- To maximize revenues and insure accurate documentation, on a monthly basis all clinical documentation related to Medicaid billings is reviewed for compliance with State and Federal regulations.
- Utilization reviews include auditing 10 percent of each clinician's clinical records each quarter to ensure (1) compliance with Federal and State (DMHMRSAS and DMAS) laws and regulations, (2) compliance with County, CSB, and Mental Health regulations, policies, and procedures, and (3) the highest quality of clinical services.

Specific to this CAPS, additional training and staff development needs include the following:

As a result of state statutory changes in 1996, the training requirements for Emergency and MCU clinicians are extensive. In addition to comprehensive training on psychotropic medications (antidepressants, antipsychotics, mood stabilizers, anxiolytics, etc.), the following also is required in accordance with the Code of Virginia: comprehensive risk assessments, detailed mental status examinations; crisis intervention and crisis stabilization; geriatrics; pediatric substance abuse evaluations; Federal statutes (42 CFR Part 2) and State (DMHMRSAS and DMAS) and Federal (Health Care Finance Administration) regulations. Staff must also be trained and certified by the Office of Medical Services of the Virginia Department of Health in Critical Incident Stress Management and by the Federal Bureau of Investigation in Hostage/Barricade Negotiation Techniques. It takes approximately two years for a full-time clinician to become fully certified to provide the range of Emergency and Mobile Crisis Unit services.

Community Outreach

Mental Health Emergency and Crisis Services provide community outreach primarily through the MCU and the CISM /Disaster Response Team.

Accomplishments

- During FY 2001, Emergency Services and the MCU provided emergency clinical interventions to 6,406 clients. Yet, despite the fact that these individuals are the highest risk and most severely disturbed CSB clients, the 33,007 services provided (crisis intervention, crisis stabilization, psychopharmacology, and admission to crisis residential services) were so successful that inpatient psychiatric hospitalization was avoided more than 97 percent of the time.
- From FY 2000 to FY 2001, the Crisis Care Program showed a dramatic increase in utilization. While the number of clients served increased by only 39 percent (from 192 to 266), the number of days of treatment increased by 70 percent (from 1,845 to 3,136). This increase reflects not only the critical and increasing need for community-based treatment alternatives to psychiatric hospitalization, but also reflects the increasing level of clinical pathology of those clients being maintained within the community.

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- Following the tragic events at Columbine High School in Colorado, a project was initiated to gather state-of-the-art information about the assessment and treatment of young people at risk for violence. Using information from the FBI, research projects – both published and unpublished – and the considerable risk assessment experience of Emergency and MCU clinicians, a screening tool was developed and a consultation model was put into place. This has been of substantial value, particularly for FCPS.
- During FY 2001, the MCU developed a 25-page manual specifically for police officers that serves as a practical reference for handling situations on the street involving mentally ill citizens and includes ways to access immediate, as well as longer term, psychiatric interventions for these citizens. The manual includes triage charts, Virginia Code citations, resource telephone numbers and programs, hours of operation, names of contacts, etc. It was distributed, via Roll Call trainings, to every “street” police officer in the five Police Departments within the service area (Fairfax County, the Cities of Fairfax and Falls Church, and the Towns of Herndon and Vienna) and has been very well received.
- The MCU actively collaborates with the Police Department in the training of street officers who are “first responders” to potential hostage/barricade situations. The training is a weeklong event of police and psychological coursework and concludes with a full dress hostage simulation that takes up the entire final day of training. Since its inception, the number of hostage or barricade situations in the County has dropped significantly to total only four in FY 2001.
- During FY 2001, the Women’s Crisis Shelter received a grant from the Virginia Department of Social Services for rental and operations for five new crisis beds. In addition, the Women’s Crisis Shelter added a house that would allow up to two families to extend their crisis stay past 21 days when no other housing was available. For FY 2002, the Women’s Crisis Shelter has received funding to open an additional 12 beds with staffing outsourced to the private sector.

Participant Characteristics

Patients seen through one or more of Emergency and Crisis Services’ programs carry a range of diagnoses and problems including:

- Schizophrenia
- Acute Psychoses
- Severe Depression
- Mania
- Severe Personality Disorders
- Eating Disorders
- Substance Abuse/Dependence Disorders
- Substantial Suicide and Homicide Risk
- Self-mutilating Behaviors
- Domestic Violence
- Child or Elder Abuse

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- Involvement with the Criminal Justice System
- Homelessness
- Any other acute psychological and psychiatric disorder that involves extraordinary crisis and distress

► Trends/Issues

Increasing Multicultural Population - The percentage of men, women and children in the service area from other cultures is growing dramatically. To meet the clinical needs of these growing populations, emergency psychiatric programs must hire front-line clinicians who are culturally competent and multilingual. Such clinicians are in high demand and, as a County agency with salary constraints, it is extremely difficult to successfully compete in the hiring market for these critically needed clinicians.

Increasing Costs of Psychotropic Medications - The past ten to fifteen years have seen a revolution in new and far more effective psychotropic medications that are available for the treatment of depression and psychosis. In the case of depression, a family of medications called Selective Serotonin Reuptake Inhibitors (SSRIs) has become the "first line" prescription. SSRIs are not only far more effective than the older tricyclic and Monoamine Oxidase Inhibitors (MAOIs) antidepressants, but they have none of their lethal overdose potential. In the case of psychosis, a class of drugs called atypical antipsychotics (ATPs) has had a dramatic impact on the successful treatment of schizophrenia and, as with the SSRIs, have far fewer side effects than the antipsychotic medications used in the past. However, in addition to their unquestioned effectiveness, SSRIs and ATPs share another characteristic - considerable cost.

Increasing Volume of Emergency/MCU Patients - There is an increasing number of people in the service area - as in virtually every other jurisdiction in the United States - who are underinsured or uninsured. These individuals tend to postpone seeking help until a treatable illness becomes a life-threatening emergency. In only one year, from FY 2000 to FY 2001, the number of clients served by Emergency/MCU increased by 11 percent (from 6,563 to 7,313), while the number of services provided increased by 16 percent (from 28,414 to 33,007).

Increasing Severity of Diagnosis - As a result of the shift from hospitalization in State psychiatric facilities to community-based care and the lack of insurance to pursue treatment within the private sector, the severity of psychiatric disorders seen in the various Emergency and Crisis Services has increased significantly. This can readily be seen in the 38 percent increase (FY 2000 to FY 2001) in clients being served by the Crisis Care Program, the 70 percent increase (FY 2000 to FY 2001) in bed day utilization of Crisis Care, the 28 percent increase (FY 2000 to FY 2001) in the number of clients being detained and evaluated by the Civil Commitment Program, and the 30 percent increase in services provided in that program.

Increasing Documentation Requirements - To comply with new requirements imposed by State licensure, DMHMRSAS State Performance Contract, and Medicaid, the amount of documentation has increased dramatically. The time required for clinicians and psychiatrists to complete this documentation is time formerly dedicated to serving high-risk clients.

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► **Method of Service Provision**

Services are provided in both directly operated and contracted programs licensed by DMHMRSAS with each program designed to serve a specific population or meet a specific emergency need.

- **Emergency**

Woodburn Center (central County): 24 hours a day, seven days a week (including holidays)

Northwest Center: Monday through Friday, 9:00 a.m. to 5:00 p.m. (excluding holidays)

Mt. Vernon Center: Monday through Friday, 9:00 a.m. to 5:00 p.m. (excluding holidays)

- **Mobile Crisis Services**

MCU: Sunday through Saturday, 8:00 a.m. to 12:00 a.m. (including holidays)

Hostage/Barricade Team: On-call response 24 hours a day, seven days a week

CISM/Disaster Response Team: On-call response 24 hours a day, seven days a week

- **Entry and Referral**

Monday through Friday, 9:00 a.m. to 5:00 p.m. (excluding holidays)

- **Crisis Care Program**

Gregory House, Alexandria: 24 hours a day, seven days a week (including holidays)

Leland House, Centreville: 24 hours a day, seven days a week (including holidays)

- **Women's Crisis Shelter**

Undisclosed location: 24 hours a day, seven days a week (including holidays)

- **Inpatient**

Inpatient Psychiatric Beds: 24 hours a day, seven days a week (including holidays)

Discharge Planner: Monday through Friday, 10:00 a.m. to 6:00 p.m. (excluding holidays)

- **Civil Commitment Program**

Evaluations: On-call Sunday through Saturday, 6:30 a.m. to 11:00 p.m. (including holidays)

Hearings: Monday through Friday, 6:45 a.m. to 12:00 p.m. (excluding holidays)

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► Performance/Workload Related Data

| Title | FY 2000 Actual | FY 2001 Estimate | FY 2002 Estimate |
|--------------------------------|-------------------|---------------------|---------------------|
| Persons Served: | | | |
| Emergency/MCU | 6,563 | 7,313 | 7,313 |
| Crisis Care Program | 192 | 266 | 266 |
| Women's Shelter | 230 | 260 | 260 |
| Inpatient | 211 | 193 | 193 |
| Civil Commitment Program | 365 | 469 | 469 |
| Services Provided: | | | |
| Emergency /MCU (services) | 28,414 | 33,007 | 33,007 |
| Crisis Care Program (bed days) | 1,845 | 3,136 | 3,136 |
| Women's Shelter (bed days) | 3,101 | 3,145 | 3,145 |
| Inpatient (bed days) | 847 | 736 | 847 |
| Civil Commitment (hours) | 989 | 1,288 | 1,288 |

► Mandate Information

This CAPS is Federally or State mandated. The percentage of this CAPS' resources utilized to satisfy the mandate is 76 - 100%. The specific Federal or State code and a brief description of the code follows:

- Code of Virginia Section 37.1-194 mandates provision of emergency services as a core service within the Community Services Board (CSB).
- Code of Virginia Section 37.1-197.1 mandates the CSB to provide prescreening services for anyone who requires emergency mental health services.
- Code of Virginia Section 37.1-65 mandates the CSB to complete an evaluation and prescreening for any person requesting admission to a State hospital, including private psychiatric beds purchased with State funds
- Code of Virginia Section 37.1-67.01 mandates CSB evaluation of individuals under an Emergency Custody Order.
- Code of Virginia Section 37.1-67.1 mandates that all CSB emergency clinicians who initiate involuntary hospitalization must be certified, after having successfully completed a specialized training program as approved by the Department of Mental Health, Mental Retardation and Substance Abuse Services and mandates the CSB to (1) complete an "in person" evaluation of patients prior to the issuance of a Temporary Detention Order, (2) provide a clinical recommendation to the Magistrate regarding the issuance of such an order, and (3) locate a bed for the detainee.
- Code of Virginia Section 37.1-67.3 mandates the evaluation of patients under a Temporary Detention Order to determine if the individual (i) is or is not so seriously mentally ill as to be substantially unable to care of himself, or (ii) does or does not present an imminent danger to himself or others and (iii) does or does not require involuntary hospitalization and mandates the CSB provide a preadmission screening report for the civil commitment hearing and mandates the CSB to find a commitment bed as a "willing" facility.

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- Code of Virginia Section 37.1-89 provides for fees and expenses for many of the services provided under 37.1-67.1 through 37.1-67.4.
- Code of Virginia Section 16.1-338 for minors under the age of 14 or "nonobjecting minors" fourteen years of age or older, mandates the CSB to complete an evaluation and prescreening for any person requesting admission to a State hospital, including private psychiatric beds purchased with State funds.
- Code of Virginia Section 16.1-339 for minors fourteen years of age or older who are objecting to psychiatric hospitalization, mandates the CSB complete an evaluation and provide a written report to include findings as to whether, because of mental illness, the minor (i) presents a serious danger to himself or others to the extent that severe or irreparable injury is likely to result or (ii) is experiencing a serious deterioration of his ability to care for himself in a developmentally age appropriate manner, and (iii) is in need for inpatient treatment for mental illness which is (iv) the least restrictive alternative that meets the minor's needs.
- Code of Virginia Section 16.1-340 mandates CSB evaluation of minors under an Emergency Custody Order and mandates the CSB to (1) complete an "in person" evaluation of minors prior to the issuance of a Temporary Detention Order, (2) provide a clinical recommendation to the Magistrate regarding the issuance of such an order, (3) complete a preadmission screening report and (3) locate a bed for the detainee and mandates that all CSB emergency clinicians who initiate involuntary hospitalization on a minor must be certified, after having successfully completed a specialized training program as approved by the Department of Mental Health, Mental Retardation and Substance Abuse Services.
- Code of Virginia Section 16.1-342 mandates the CSB to complete an evaluation and provide a written report to include findings as to whether, because of mental illness, the minor (i) presents a serious danger to himself or others to the extent that severe or irreparable injury is likely to result or (ii) is experiencing a serious deterioration of his ability to care for himself in a developmentally age appropriate manner, and (iii) is in need for inpatient treatment for mental illness which is (iv) the least restrictive alternative that meets the minor's needs.
- Code of Virginia Section 16.1-344 mandates the evaluator to submit the written report (as defined under 16.1-342) to the Court and to attend the hearing as an expert witness.
- Code of Virginia Section 16.1-345 mandates that CSB designate the inpatient treatment facility for minors committed under 16.1-344.
- Code of Virginia Section 16.1-347 mandates sole CSB responsibility for evaluation of patients for involuntary hospitalization in the Commonwealth and authorize CSB emergency clinicians to recommend and facilitate involuntary hospitalizations for adults and for juveniles.
- Code of Virginia Section 16.1-345 provides for fees and expenses for many of the services provided under 16.1-388 through 16.1-342.
- Code of Virginia Section 44-146.19 E mandates Critical Incident Stress Management/Disaster Response Team as part of the Fairfax County Disaster Operations Plan.
- Code of Fairfax County Section 14-1-5 mandates Critical Incident Stress Management/Disaster Response Team as part of the Fairfax County Disaster Operations Plan.

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► User Fee Information

| Subobject Code | Fee Title | FY 2002 ABP Fee Total |
|---|--|-------------------------------------|
| N/A | FY 2002 CSB Schedule of Fees. The current fee schedule is available in the Agency Overview. | \$366,196 |
| Current Fee | | Maximum Allowable Fee Amount |
| Once the treatment plan is determined, the fees for services will be set according to the FY 2002 CSB Fee Schedule. | | N/A |
| Purpose of Fee: Fees are charged to offset the cost of providing treatment services. | | |
| Levy Authority | Requirements to Change the Fee | Year Fee Was Last Adjusted |
| CSB Policy on Reimbursement <u>Code of Virginia</u> Chapter 10, 37.1-197(7) | The CSB Schedule of Fees is reviewed and established annually by the CSB Board and submitted to the Board of Supervisors. The client or other legally responsible party is responsible for paying the full fee for services. A client or other legally responsible party who is unable to pay the full fee may request a subsidy, supplemental subsidy and an extended payment. | 2001 |
| Other Remarks: | | |